AMERICAN MEDICAL TIMES

Being a Weekly Series of the New York Journal of Medicine.

No. XXI. Vol. V. } New Series. NEW YORK: SATURDAY, NOVEMBER 22, 1862. { *Mail Subscribers, $3 per Ann.* *City and Canadian, 3 50 "* *Single Numbers, 10 cents.*

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Letter from one of the Surgeons of the University Hospital, Nashville, Tenn.

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On Diphtheria. By Edward Headlam Greenhow. 1861. Pp. 160. Price, $1.25.

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SESSION 1862-63.

BY AUSTIN FLINT, M.D.
PROFESSOR OF THE PRINCIPLES AND PRACTICE OF MEDICINE.

LECTURE VII.—PART I.

Absence of Organic Murmurs in Cases of Enlargement of the Heart, as Evidence of the latter existing independently of Valvular Lesions.—Modifications of the First Sound Produced by Hypertrophy and Dilatation.—Diagnosis of Softening and Fatty Degeneration of the Heart.

GENTLEMEN:—In my first lecture I considered the means of determining enlargement of the heart, and I stated that, in the great majority of cases of enlargement, valvular lesions are found to exist. In considering the diagnosis of valvular lesions in the last three lectures, I have had occasion repeatedly to refer to the production of hypertrophy and dilatation as effects of obstructive or regurgitant valvular lesions. Enlargement of the heart, however, in a small proportion of cases, occurs without being associated with lesions of the valves. We determine the coexistence of valvular lesions and enlargement, by finding, in addition to the signs of the latter, one or more of the different organic murmurs of which I have treated at considerable length. And we determine the existence of enlargement without valvular lesions, by finding that none of the organic murmurs are present. As a rule to which there are but few exceptions, absence of murmur warrants the conclusion that valvular lesions do not exist.

In my first lecture, also, I considered the means of determining whether enlargement of the heart be due to predominant hypertrophy or to predominant dilatation. Additional means of making this discrimination consist in modifications of the heart-sounds. These I could not present until the characters which belong to the heart-sounds in health had been considered. Let me now point out these additional means of diagnosis. They relate to the first sound of the heart. This sound is modified differently in cases of enlargement, according to the kind of enlargement, that is, whether it be by hypertrophy or by dilatation.

If the heart be hypertrophied, the augmented power of the ventricular systole increases the element of impulsion of the first sound. This effect is especially marked in proportion as the left ventricle is hypertrophied. The movements of the apex against the thoracic walls take place with an abnormal force, and the sound thereby produced is correspondingly greater than in health. The increase of the element of impulsion renders the first sound not only louder than in health, but longer, and the booming quality is more marked. In cases of enlargement, then, increased loudness and length of the first sound, with the booming quality strongly marked, denote that the enlargement is due to predominant hypertrophy, and that the left ventricle, especially, is hypertrophied.

On the other hand, if the heart be dilated, the ventricular systole being proportionately weakened, the element of impulsion in the first sound is feeble, or, perhaps, altogether wanting. In great weakness from dilatation, there is no element of impulsion; the valvular element alone is appreciable. And in proportion as the element of impulsion is deficient, the first sound is weak, short, and the booming quality absent. If the element of impulsion be altogether wanting, the first sound is as short as the second sound; it is valvular in quality like the second sound, and weaker than the second sound even directly over the apex. In cases of enlargement, then, relative weakness of the first sound, with shortness of this sound, and the valvular taking the place of the booming quality, denote that the enlargement is due to predominant dilatation.

These effects of dilatation lead us to the consideration of the diagnosis of softening and of fatty degeneration of the walls of the heart. Softening of the heart occurs in certain cases during the course of the continued fevers, and occasionally in some other diseases. Fatty degeneration involves softening, and occurs not unfrequently either with or without enlargement, and with or without valvular lesions. Of softening either from fatty degeneration, or otherwise, the effect is to weaken the power of the heart's action, and, as a consequence, the first sound of the heart is weakened and modified. The change in the first sound is the important physical sign taken in connexion with the associated circumstances pertaining to the history and symptoms.

If, in the course of typhoid or typhus fever, the first sound of the heart becomes, as compared with the second sound, feeble, losing the element of impulsion, and, hence, becoming short and valvular in quality like the second sound, even when the stethoscope is applied over the apex, we have grounds for supposing that softening has occurred. Dr. Stokes has called attention to these modifications of the first sound, and the extinction of this sound in some cases, as indications for the use of alcoholics in continued fever. These changes as regards the first sound constitute a better criterion of weakness of the heart's action than the pulse, and, therefore, auscultation of the sounds of the heart should not be neglected in watching the course of these, and, indeed, other forms of fever.

The diagnosis of fatty degeneration of the heart, so far as physical signs are concerned, is based on the same modifications of the first sound, together with the absence of much enlargement, and of organic murmurs. Fatty degeneration, especially if the left ventricle be affected, weakens the heart's action, and, consequently, the element of impulsion of the first sound is impaired or lost; and if this sound be divested of the element of impulsion, it becomes short and valvular like the second sound, but, as we have already seen, less intense, or even inappreciable at the apex. Absence of usual enlargement and of organic murmurs, is an important point in the diagnosis, because similar modifications of the first sound may be due to dilatation of the heart either with or without valvular lesions. Organic murmurs represent valvular lesions, and the existence of these, with enlargement, contributes to render dilatation probable; but, even without organic murmurs, if the heart be much enlarged, the probability of sufficient dilatation to account for the weakness of the heart's action, renders the diagnosis of fatty degeneration problematical.

But fatty degeneration may coexist with valvular lesions and more or less enlargement. The diagnosis is then not so easy. We may, however, in certain of these cases, determine, with considerable positiveness, the existence of fatty degeneration. The diagnosis is to be based on the fact that the enlargement is not enough for an amount of dilatation sufficient to explain the existing weakness of the heart's action.

In determining the existence of fatty degeneration, with or without valvular lesions, other circumstances than the signs are to be considered. The age of the patient is one of these circumstances. Fatty degeneration of the heart rarely occurs in youth, or the early part of middle age. If the patient be over forty or fifty years of age, the probabilities of this lesion are much greater than if the patient has not reached these periods of life.

A tendency to the deposit of fat throughout the body, or obesity, is another circumstance. During middle age the fatty diathesis is apt to become developed; and, although fatty degeneration of the heart may occur in those who are not corpulent, but spare, it oftener occurs in those who manifest a general tendency to the deposit of fat.

The *arcus senilis* is another circumstance. Many persons undoubtedly have this fatty change of the cornea who do not have fatty degeneration of the heart, and *vice versâ*. It has not the diagnostic significance attributed to it by Canton, who was the first to show its pathological character; but it is entitled to some weight in the diagnosis.

Finally, a tendency to syncope on exertion, and the occurrence of the pseudo-apoplectic seizures, not accompanied by stertor and not followed by paralysis, which have been described especially by Stokes, concur with physical signs, and the foregoing circumstances, in strengthening the diagnosis of fatty degeneration of the heart.

Original Communications.

REMARKS ON ALBUMINURIA,

MADE BEFORE THE NEW YORK ACADEMY OF MEDICINE.

By A. CLARK, M.D.,

PROF. OF PRACTICE AND PATHOLOGY.

(*Concluded from* p. 271.)

In the acute attacks, where the œdema is rapidly produced, including the form which follows scarlet fever, and that which attends and follows pregnancy, a large proportion recover. Frerichs thinks that of those who have the acute disease, excluding the two special forms, two thirds get well. If this estimate were to include the scarlet fever cases, I must claim a much larger proportion of recoveries. This is the most common form of the disease often called "acute dropsy," or "acute œdema." The treatment which has seemed to me most useful is the diaphoretic. Cups, with scarifications to the loins in adults, and in persons full of blood possibly a small bleeding from the arm, are often important aids; and a brisk cathartic is undoubtedly useful; but the external diaphoretics are my chief reliance. The warm bath, continued for twenty minutes or half an hour, at the onset, and a warm bed to keep up the perspiration produced by the bath, and after that the frequent use of the foot bath, under the bedclothes, so as to keep the skin moist for days together, if need be, will do more to relieve the kidneys of their congestion, renew their healthy action, carry off the œdematous effusion, and protect from cerebral oppression and convulsive attacks, than all other means together. With children, after scarlet fever, it often happens that they cannot be kept in bed. They do not feel ill, though the whole body is swollen, until the urea begins to paralyse the nerve forces of the brain, provokes inflammation of some serous membrane, or causes coma, or explodes in convulsions. In case the child cannot be kept in bed, it is best to cover him with flannel garments warmly, keep him in a room of sufficient size, the temperature of which is preserved steadily at 72°, and let him follow his amusements, interrupted, from time to time, if the skin ceases to be moist, by the footbath. The bed, however, is the safest place, and well disciplined children can be kept in it. Food should be given sparingly at first, but increased as the disease diminishes, or as time or a tendency to chronicity may demand nutrition. Iron is of little use, except in protracted cases. The bowels should be moved daily.

Regarding the form of Bright's disease which accompanies pregnancy, it is important to say that, in general, these and all other means are merely palliative, and are never used with the perseverance which is so often rewarded in the cases just alluded to. It is only after delivery that they give much promise of permanent relief. In these cases the gravid uterus, or at least the state of pregnancy, produces and keeps up the affection, and while this state continues the power of medicine is limited. It is true, that up to the time of parturition, the dangers are not usually great though the inconvenience or often the suffering is considerable; but it is fair to assume that every day is adding something to the disorganization of the kidneys, and increasing the risks of congestions, inflammations, convulsions, and coma, when the crisis arrives. These facts have so deeply impressed the minds of those who are much engaged in obstetrical practice, that the question has been seriously entertained, "whether premature labor should not be induced." I need not say this is a grave question, and can only be decided by deliberately weighing the dangers of the disease in one scale and the dangers of the interference in the other. After the uterus has been relieved of its burden, and after the dangers of the puerperal state are passed, though, in the majority, the albumen disappears in a few days and convalescence is pretty rapid in many cases, there is still a long illness to be endured. The disordered kidneys will often require two, three, or even more months to throw off their load of exudations, and regain their natural structure. During this time the symptoms of Bright's disease continue, and the disease will require nearly the same treatment as the chronic form.

The chronic disease is sometimes the result of the acute, but much more frequently it makes its approaches insidiously; it produces no pain, it gives no alarm, it mines in the darkness until the patient's waning strength, pale countenance, and swollen feet or face suggest to him the need of professional advice. The disease is established, and is probably incurable before we are aware of its existence. Our thoughts, under these circumstances, turn to the cause or causes which have produced this state. If the patient is a spirit-drinker, he should abandon the use of alcoholics, till for some good reason his physician advises them. If, in his employment, he has been exposed to cold and moisture, if there have been errors of diet producing dyspepsia, these are in general avoidable causes. The warmth and secretion of the skin are to be secured. The bowels are to be soluble; a mild purge occasionally may assist in relieving the congested kidney; cups dry, or in the early stage, with scarifications, perhaps, are favorite applications, and are theoretically admissible; travelling, or easy exercise in the open air, during the mild season, and a sea voyage, have each had a beneficial influence; and among the many medicines which have from time to time been urged as general remedies, one and one only has been received with general favor—iron, in one or other of its approved forms. At one time it was hoped that the mercurials or the compounds of iodine, by their alterative powers might restore the kidneys to soundness, but experience has crushed these hopes. There is probably no more powerful derivative fron the kidneys than the vapor or hot air bath; one or other should be used at least once a day. The perspiration so induced should be continued for an hour in bed. The surface after this perspiration should be rubbed with a dry towel till it is red, to enable it to resist the cold, and then the patient may dress and go about as usual.

On the other hand, there is probably nothing among the avoidable agencies more pernicious than cold, and the bad effects of cold are heightened by dampness. Hence there is no rule more important than that which enjoins the full protection of the body against these influences. This statement will not require a more striking illustration than the following case, which for brevity I greatly abridge. (Case 24, of the Case Book.) This man was first treated by the sweating plan. Very little perspiration, however, could be induced; and after a protracted trial the external diaphoretics were abandoned. The corrosive chloride of mercury was then tried, with no important result, however. Purgatives were used pretty freely. Nothing so far had produced any very decided impression on the patient's condition. Still he did not grow worse till one day, without my knowledge, the floor of the ward (basement) was partly taken up for repairs, admitting freely the cold air from the cellar. This was about the 16th of November. This unfortunate draught was allowed to continue two days. I did what I could as soon as the fact came to my knowledge, which was on the second day, to protect the patient from

the effects of this mischance. But in the first twenty-four hours the dropsical accumulation had much increased, and in two or three days more the dyspnœa became extreme, the face swollen, the lips purple. He lingered in this state two days. The heart was hypertrophied, weighing 17 oz., but there was no valvular disease or adhesion of the pericardium. The lungs were in the highest degree œdematous. These are the lungs referred to on page 487. The kidneys weighed 7oz. each, and were almost as white as milk.

It is worthy of particular note that two other patients in the same ward, suffering from the same disease, grew rapidly worse, under the action of this cold air, but did not die from the train of disasters immediately following it.

To remove the dropsy, *baths* used in the way just indicated are among the most efficient means. For this purpose they may be taken twice a day. The patients often complain that they are weakened by them; but though a temporary feeling of weakness or lassitude follows them, the strength usually increases as the anasarca is removed. *Purges* are sometimes necessary for the removal of serous accumulations. Epsom salts and fluid extract of senna have been longer and better borne than any other which I have tried. The elaterium has great power, but its drastic properties make its frequent repetition dangerous. Nothing will replace it, however, in certain emergencies. Pulvis purgans is well borne by most persons; but the cremor tartar alone an ounce or so a day, or every second day, will often rid the system of a great deal of water with only moderate irritation. *Diuretics* have been given in this disease with hesitation. Their action is in the highest degree uncertain. There is, I believe, a very general conviction, that the irritating articles of this class should be prohibited. There is reason to suppose that cantharides and turpentine should not be used even as applications to the surface. But I do not hesitate to use the acetate of potassa, the iodide of potassium or infusion of digitalis freely, and am persuaded that life has been prolonged by them. Theory would teach us not to stimulate a congested kidney; but observation does not convince us, when the morbid fluids are evacuated by these agents, that the chances of life are not as good as when the same result is accomplished by purges. The decoction of apocynum cannabinum is a favorite with some physicians. I hardly know whether to speak of it as a diuretic or cathartic; it may act as either or even both. It is a very powerful medicine, and has at times done what nothing else would do. But often the stomach will not tolerate it, and its depressing influence is too great. I rarely use it now unless driven to it by the failure of other means. Acupuncture or lancet-punctures, in swollen limbs, will give some temporary relief when the internal evacuants have failed. The serum will commonly drain from these little openings in great quantity and unload the body as well as the legs, but the uræmia predisposes to inflammations everywhere, and this tense skin is especially liable to it. I have seen these punctures provoke fatal eyrsipelas many times in hospitals, and more than once in private practice. The skin often bursts in little fissures or is blistered when distended by œdema; then the fluid will escape as when punctures have been made. An erythema commonly attends these spontaneous openings, but erysipelas very rarely. Nature's openings are in this respect better than ours, but they are tardy. Bandages are nearly useless, except when the anasarca is inconsiderable. It has been urged against them that they cause absorption of the serum with the urea it contains, and by more deeply poisoning the blood produce dangerous cerebral symptoms. I have seen nothing that would lead me to apprehend such a consequence, but they often irritate the swollen limbs, and provoke a little cutaneous inflammation which compels us to abandon them. This inflammation, however, is not usually dangerous, and the bandages may be used so long as they add to the patient's comfort.

Œdema of the lungs is very common in the progress of this disease, and it is usually attended by a bronchorrhœa that fills the tubes with mucus, and the chest with râles, and makes the breathing most difficult. It is when the heart and kidneys suffer together that this œdema and this bronchorrhœa, one or both, are most troublesome. They usually come on slowly, increasing step by step, as the general œdema increases, till they reach a degree which compels the patient to abandon the bed and get what sleep he can in his chair. This is a condition which will not commonly admit of more than temporary relief. The treatment does not differ much from that to which we resort to overcome the general œdema. A brisk purge will sometimes permit sleep for one or two nights, when, if it is not repeated, the same distressing condition returns. But a purge daily will at length exhaust the vital energies. It is a sad alternative. It is, however, a choice between death imminent and death delayed. In some of these cases, when the lungs are not too greatly loaded, an anodyne in moderate dose acts kindly, and gives rest for a few nights. But the sudden pulmonary œdema is the most alarming. It comes like a foe in ambush, and gives no warning. I believe the best we can do in such an attack is to cover the chest with dry cups, put the feet into warm water as the patient sits in his chair, for he cannot lie down unless he becomes insensible; give him to inhale Hoffman's anodyne or sometimes the vapor of warm water, and if it is protracted, a purge. I have had oxygen and nitrous oxide administered by inhalation with the happiest effects; but these require time in their preparation, and the patient is usually relieved, or sometimes dies before either of them can be got ready. Where these attacks are regularly periodical, as happens only rarely, we are tempted to give quinine in the intervals. My observation will not enable me to speak very confidently of its preventine qualities. This kind of œdema often abates without wholly subsiding, and remains still as a source of distress for days and weeks. Then it identifies itself with the more chronic form just referred to, and requires the same treatment. In a case of this kind that I saw in the practice of Dr. Geo. T. Elliot, the very pleasantest effects were produced by the injection of a solution of sulphate of morphine under the skin, used only in small quantities. Similar effects I have seen in other cases from applying the sixth or the eighth of a grain of the undissolved sulphate to a blistered surface.

Over the convulsions, when they occur, we have but a limited control. Where they attend the contracted kidney, they are not usually preceded by weakness and marked cachexia, and the patient will usually bear a moderate bleeding from the arm, and a few leeches to the temples, and an active purge. Beyond this, diaphoresis secured by the foot-bath in bed, the prudent use of chloroform to diminish the severity of the spasmodic paroxysms, and cooling applications to the head, will constitute about our whole duty. If our patient does not die in a convulsion, his chances of escaping the consequent congestions or apoplexy are unfortunately but too few. When this formidable symptom (for, terrible as they are, these convulsions are only an evidence and manifestation of urea in the blood) occurs with the large white kidney, it is after œdema has existed for a considerable time after the cachexia is established. We do not under these circumstances attempt venesection. We apply leeches hesitatingly and sparingly; we are almost limited to the purge, the foot-bath, and the chloroform. It is worthy of remark that in the range of my experience, convulsions occurring in persons having the large white kidney are less fatal than when they are associated with the opposite state of the organ. This result cannot be explained by the treatment adopted, for too often in the latter, death has occurred before any active treatment has been instituted.

For the amaurosis of fatty degeneration of the retina I know of no specific or special treatment. I have said that if the symptoms generally are ameliorated, the vision will in most cases be improved. The treatment of this symptom is the treatment of the principal disease.

For the dyspeptic symptoms and the flatulency, our means of relief are limited to the selection of food, according to

the patient's experience of its kind or unfavorable action on the stomach, and the use of stomachics, particularly pepsine and the nitro-muriatic acid, or the carminatives.

There is a diarrhœa sometimes in course of Bright's disease, which, when it occurs, is usually very obstinate. I have found that it is sometimes controlled by the Oak Orchard Acid spring water, which contains some free sulphuric acid and many sulphates, or by the pernitrate of iron.

The uræmic vomiting, when it occurs, is also very obstinate. Its proper treatment is the treatment for uræmia. But this is usually unsuccessful, and we are left commonly to do the best we can with that unpleasant symptom. Blisters and counter-irritations of all kinds over the stomach are entirely useless. One or two drops of hydrocyanic acid, or the cold carbonic acid water, will sometimes soothe for a little while, and creasote has been recommended. It is often relieved for a time after free perspiration. But in truth, we cannot do much with it. Nutritive injections into the bowel have been tried, to give the stomach rest, with temporary relief.

Hæmaturia, when it occurs in this affection, is usually an early symptom. It is sometimes the first that attracts attention. For this I rely chiefly on tannin and the fluid persulphate of iron as internal medicines, cups to the loins, and the warm bath.

Finally, regarding the inflammations which occur in the course of Bright's disease; they are very formidable, as appears from the great mortality they produce; yet in general they do not admit of a treatment varying much from that which the same conditions require when they occur alone. The meningitis (secondary) is almost invariably fatal. Every variety of treatment with which I am acquainted has failed. I have, therefore, no suggestion to make. But the pleurisy, if it is the only complication, will usually yield to cups, blisters, and diuretics, as it does when it occurs singly. Diuretics, however, always uncertain, are unusually so when the kidneys are diseased; and the external diaphoretics may be substituted for them. The pericarditis of Bright's disease when it occurs upon an old heart affection, and when the dyspnœa is already considerable, will generally be fatal; but as it commonly presents itself, its natural tendency is to recovery, and beyond cups, soothing doses of opium, a blister, and evacuants, it demands but little medication. The mercurials do not appear to render the recovery any more certain, or any more rapid. The pneumonia is more grave, and yet many recover from it. When this disease occurs as a primary affection our treatment is rather energetic; but in the management of it in this connexion, we must remember that pneumonia *can* get well without treatment. The usual means then must be modified to meet the enfeebled condition of the patient, and the impoverished state of his blood. Peritonitis, always formidable, is doubly so in Bright's disease. Many of us now rely almost entirely on the antiphlogistic powers of opium, to combat it as it ordinarily occurs; but we are limited in the use of this drug by the diminished tolerance of it in the uræmic; still, used prudently, and in view of this fact, it is our best medicine. Dysentery in this connexion has not received any new treatment. It will usually bear leeches to the arms, but not general blood-letting. Erysipelas, though of frequent occurrence, did not cause death in the catalogue of cases I have presented. In a larger number of cases it will find a place. Ordinarily, however, it yields to the soothing local applications, and the general sustaining and tonic plan which fortunately is now in general favor. Cirrhosis is not, strictly speaking, one of the inflammatory complications of Bright's disease; but the two affections occur together often enough to fix our attention. I refer to the fact here for the sake of saying that any considerable amount of abdominal dropsy is not a feature of the renal, but it is of the hepatic disease; and that tapping, when it can possibly be avoided, is an expedient of very doubtful propriety. Peritonitis so often follows the trocar under other circumstances, that we are not authorized to take the risks of it till other means are exhausted, and the patient's life is in danger from dyspnœa.

Now, Mr. President, the task which I have appointed for myself is done, and I return to you, Sir, and to the Fellows, my thanks for the patience and attention with which you have listened to these protracted and tedious details, which however far from exhausting the topic, I fear you will think too much extended for the opening of a discussion. The remarks, such as they are, I submit, with the assurance that the ability and learning of gentlemen who are prepared to offer the Academy their opinions and facts will correct any errors into which I may have fallen, and extend our knowledge of this terrible disease and its relations. Before I sit down I ought, perhaps, to apologize for violating in some measure the promise implied in the statement made when the Academy first entertained this subject. Several weeks have elapsed since that statement was made, and I have not thought it wrong to study the subject in some of its branches, more "elaborately" than I then supposed possible. These studies, however, I may be permitted to add, have been very fragmentary, interrupted sometimes for days, and I am sorry to find that these "*solutions of continuity*" have betrayed me into several repetitions, which in a truly "elaborate paper" would not have found a place.

I have selected from authors some statistical matter relating to points that have been considered, which I do not propose to read; but with the approval of the publication committee it may appear in the bulletin as an Appendix to these remarks.

Statistics.

Age.—Dr. Bright reports among his hundred cases, 19 small kidneys, 25 large, and 56 of which the size was probably normal, or nearly normal. The ages of those having the small kidney are stated for 13; of those having the large, for 18.

13 *Small Kidneys.*	*Age.*		18 *Largest Kidneys.*	*Age.*	
Oldest person .	55 yrs.		Oldest person .	56 yrs.	
Youngest person	15 "	1	Youngest person	17 "	
Next the youngest	40 "		Bet. 17 and 40 inc. .	"	12
Bet. 40 and 55 inc. .		12	Bet. 40 and 50 .	"	4
		—	Bet. 51 and 56 inc. .	"	2
		13			—
					18
Average age 44½ years.			Average age 34½ years.		

Dr. Wilks reports 56 cases—contracted kidneys, 33; large white kidney, 23. Of the large kidneys five were found after scarlet fever. The ages were severally 3, 4, 6, 8, and 23 years. In the person 23 years of age, the disease passed into the chronic state.

33 *Small Kidneys.*	*Age.*		18 *Large White Kidneys.*	*Age.*	
Oldest person .	73 yrs.		Oldest person .	51 yrs.	1
Youngest person	24 "	1	Youngest person	12 "	1
Bet. 30 and 40		7	At 17 and 18	"	2
" 40 and 50		9	Bet. 20 and 30	"	6
" 50 and 60		10	" 30 and 40	"	5
" 60 and 70		4	" 40 and 42	"	3
At 70 and 73		2			—
		—			18
		33			
Average age 48½ years.			Average age 30¾ years.		

These summaries will corroborate the statement regarding the ages in my own cases, Bulletin, p. 483.

The sex in Dr. Wilks's cases was as follows, viz. for the contracted kidney, females 12, males 21—for the large white kidney, females 5, males 13 (v. supra, p. 484). The sex is not deducible from Dr. Bright's reports.

Œdema occurred in Dr. Wilks's cases more frequently with the large than with the small kidney.

Dropsy with the Small Kidney.		*Dropsy with the Large White Kidney.*	
Usually slight and often temporary	in 16	Usually considerable, in a few slight	in 16
Did not occur	" 11	None	" 1
Not mentioned, probably none	" 6.	Not mentioned	" 1
	33		18

Compare these tables with the statement made, supra, p. 484. The dropsy, in these 18 cases of Dr. Wilks, lasted for four years, but not continuously, in 1; for three years continuously in 2; for five months to one year, in 6; three and a half months in 3; the duration is not mentioned in 5; no œdema in 1.

Regarding the concurrence of cardiac and renal disease, it was noticed in Bright's cases 49 times, or in only one less than one half, though the heart disease does not seem to have been considerable in a portion of them. There was hypertrophy in 29, and the heart is described as "large" in 15. Of these 49, eight had also valvular disease; three others had valvular disease alone; and one had ossification of the aorta. With the hard, or hard and contracted kidney, hypertrophy occurred 21 times, with the soft or "large kidney" 8 times. Among the thirty-three cases of contracted kidney reported by Dr. Wilks, there were 12 cases of disease of the heart, including valvular diseases. The cardiac affections are not spoken of in the account of his other cases (v. supra, p. 487).

Cirrhosis occurred six times, and fatty liver four times with Dr. Wilks's thirty-three contracted kidneys. They are not mentioned in the histories of the large kidneys. Dr. Bright reports among his hundred cases, twenty-three in which the liver was more or less granulated (cirrhosis?), but he does not recognise any relation between that lesion and the contracted kidney. He says on the contrary: "In nearly half the cases in which the liver was reported *remarkably healthy* (9), the kidneys were hard and advanced far in disease. The most advanced liver disease accompanied every variety of disease of the kidneys." "Fatty liver was found twice, and the kidneys were soft, smooth, and white, but in one case of slightly fatty degeneration, the kidneys were hard and lobulated" (hobnail), (v. supra, 485–7). I copy this statement, because it *does not* corroborate the impression that would be produced by the rather remarkable coincidences in my own cases.

Œdema of the lungs was noticed in Dr. Bright's autopsies thirty-one times, though it does not appear to have been in his view the cause of death in more than seven. In these thirty-one cases the heart was hypertrophied in 14; large in 5; affected with valvular disease, aortic, in 1; ossification of the aorta in 1 (21); no hypertrophy or valvular disease in 10=31. The state of the kidneys in these cases was as follows, viz. hard in 15; soft in 11; hard and large in 2; contracted without being hard, in 3=31 (v. supra, p. 470).

Dr. Bright had 1 death from œdema of the glottis; 13 from epilepsy or convulsions; 3 from sanguineous apoplexy; 8 died comatose, besides 2 from "cerebral irritation" (he seems reluctant to recognise secondary meningitis); 5 from peritonitis, &c. But I will cite the causes of death from Frerichs' report, as quoted by his reviewer, *Brit. & For. Med. & Chi. Rev.*, No. XVIII., p. 237, which collects the cases of Bright, Barlow, Christison, Gregory, Martin Solon, Rayer, Malmston, and his own, to the number of 241.

Uræmic intoxication,	86
Pneumonia,	20
Peritonitis,	11
Pericarditis,	9
Pleurisy,	7
Prostration from vomiting and diarrhœa,	20
" " profuse dropsical effusion,	10
" " phthisis pulmonalis,	27
" " caries of the joints,	6
" " gangrenous erysipelas,	5
Serum in the lungs and pleura,	26
Œdema glottidis,	2
Cerebral hæmorrhage (apoplexy),	6
Meningitis,	1
Cerebral softening,	1
Cancer of the stomach,	1
Phlebitis, result of venesection,	2
	240

The error in the footing of this table is apparently not the only one it contains. It embraces Dr. Bright's cases. I count from his (Bright's) tabular view, in which each case is given in synopsis separately, thirteen instances in which he believed death was caused by epilepsy or convulsions, with or without coma, not one of which appears in this table, unless they are gathered into the folds of that broad phrase "uræmic intoxication." Cerebral irritation, congestion, and effusion appear in Dr. Bright's cases, but not in the table. Meningitis appears to have caused but one death, while in my own cases it was found twice in twenty-two autopsies (v. supra, p. 487). This, too, is probably included in the first item. Dr. Bright had one death from gangrene of the lungs, and one from bronchitis, and six sudden deaths, neither of which appears in the table. The cause of death in Dr. Wilks's cases, so far as reported, and in my own, was, in one-half, some inflammatory affection. The proportion from this cause in the table is greatly reduced, a little over one-fourth.

Frerichs collects from the same authors, adding Becquerel, the complications discovered after death in 292 cases. (Rev. p. 223.) Among them there was hypertrophy of the heart in 99, in 41, associated with valvular disease; in 75 there was œdema of the lungs, and in the majority of these there was mitral disease, and in 4 of them œdema glottidis; in 27 there was pneumonia; vesicular emphysema in 22; cirrhosis was found in 26; and fatty liver in 19; apoplexy in 11, in 8 of which there were hypertrophy of the heart and valvular disease; in 40 the serous fluid of the brain was increased, in 10 markedly, and in 2 there was meningitis (Dr. Bright alone had thirteen cases of meningitis); in 81 there was inflammation and lymphy exudation on the serous surfaces, pleurisy in 25, peritonitis in 33, pericarditis in 13. "In 3 there was enlargement of the *lumbar glands*, sufficient to impede the return of blood by the renal veins."

The few statements given in this Review, relating to convulsions in the puerperal state, are worth citation in connexion with others as the basis of more extended observations on that subject (p. 242) "Of 20 cases observed by Devilliers and Regnauld, in which albuminous urine was passed by pregnant women, eclampsia followed in 9." "Eleven of Devilliers' and Regnaulds' 20 cases; 2 of Lever's 12 cases; and 3 of 7 observed by Frerichs, terminated fatally." I quote from the American edition of the Review; it probably required a type-setter either European or American to find "eleven" deaths in "9" eclampsias. The figures as they stand are not worth much. They do, however, point to a great mortality in these convulsions, and suggest a more careful examination of the matter.

Dr. Behm had 20 cases of puerperal convulsions. Of the mothers 17 survived, of the children 12. The convulsions commenced as follows: 7 before the completion of the natural term of gestation, causing premature labor in 5; 2 during the stage of dilatation; 7 after the escape of the liquor amnii and before the birth; 1 during the expulsion of the placenta; 3 after labor and during the puerperal week. Thus in 13 the convulsions began at full term, in 11 of these they continued into the puerperal week.

The Report of the Dublin Lying-in Hospital for the seven years commencing November, 1847, numbers 63 instances of convulsions. Of the mothers 13 died, of the children 25. Primiparæ 49, multiparæ 14. A few only had not œdema or albumen in the urine.

Kassing reports 16 cases of puerperal eclampsia. Of the

mothers 9 died, of the children (18) 3 were born dead. In all but one there was reason to believe that Bright's disease existed; in 10 there was œdema, mostly of the feet and face. In one case there were eighty-one paroxysms, but no œdema was found; in another there were sixty paroxysms, and no albumen discovered in the urine. The convulsions began in 10 during the dilatation period; in 1 during turning; in 3 during the first week; in 1 during the second, and in 1 during the eighth week.

Dr. Letzmann examined the urine of 131 pregnant women for albumen, beginning in most of the cases in the sixth month. He found it in 37, in 26 primiparæ and 11 multiparæ. He thought that in about one half of these the albumen had its origin in catarrh of the bladder, although he only assured himself of it in 9. He considers the albumen in the other half as evidence of Bright's disease. He holds the eclampsia also as evidence of the same affection, and leaves us to infer that about 18 of these 37 had convulsions. The mortality is not stated in the abstract from which this is quoted.

From these reports we may infer that puerperal convulsions are fatal to the mother 25 times in 100 cases, and to the child about 35 times in the 100. But we can deduce from them nothing positive as to the ratio of eclampsia to albuminous urine. As far as they go they lead to the belief that not more than one half of those who have this symptom have the convulsions.

In addition to what I have said of the symptoms of Bright's disease, it is stated (Rev. p. 233), that ringing in the ears and difficulty of hearing were noticed by Frerichs in 4 of 41 cases, and by Bright and Barlow in 6 of 37 cases, while the latter authors found 4 cases of *amaurosis uræmica* in the same 37.

ON RESECTIONS IN MILITARY SURGERY,

AT A LATE OR EARLY PERIOD OF THE WOUND.

BEING REMARKS AND FACTS ON THE PROBABILITY OF A GREATER AMOUNT OF SUCCESS IN THE LATTER.

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(*Concluded from page* 273.)

It is on these accounts that it is highly desirable a considerable part of the practice in resection in military surgery should be immediate, that the experience thus gained in the field and ambulance may determine a rule as to the best time of operation, and as to circumstances under which a variation from that rule may be made. Ordinarily, if the wound is very recent, a perfectly fresh one, it is easy to ascertain with the finger whether the bone has been struck. If it *has* been, and the evidence of a complete fracture exists, a straight incision to the bone, where it would be in resection, should be made, and extractable fragments felt for by the fingers. If these are ascertained, the operation should be continued to the end, as a complete resection. This should be the rule in the cases of comminution of the bones of the arm and leg, where that operation is preferable to amputation; but if amputation is to be done it should not be left undone until it succeed resection, and if the latter is to be done it should not be left undone until it follows a period of suppuration and inflammation of a wound, involving a shattered bone, nor until the foul and sloughing state of the limb is such as has long since passed the stage when the question *between* amputation and resection was appropriate. Either operation may be appropriate, or neither of them, when the case should be placed in the domain of therapeutics; but we cannot be in error in supposing it mistaken to leave both undone because we fail in a decision, and long afterwards to perform one—resection—when the tissues have become wholly disqualified to accomplish its aim or intention; and also leave undone the other and perform it when the destructive morbid process and the prior operation, which fails, have done their ruinous work, and leave but little, perhaps no chance, for success in amputation.

Particularly do the above truths exist in the case of wounds of the thigh, with comminution of the femur, shaft, or head, in cases of which it is, more strongly than in the others, true, that to operate for resection long after the period of suppuration was established is almost certain to prove a failure and, perhaps, a fatality. This is exemplified in the cases of this bone I have presented. Here any operation should be done while the wound is freshest, even if the operation be of the character of resection, and proceed to no further extent than the cutting down freely and extracting *all* the pieces whose consolidation with the tissues has been broken, with the cutting away of all the ragged and pointed parts. Perform when the wound is freshest, in these cases, if amputation be decided as best. If neither of those is decided on, then we have properly *excluded* any other operation at a later period, and this states precisely what should be. For nothing can be more revolting to all the dictates of conservative surgery than, resection having failed—the condition of the patient being that of inability to recover from it—amputation should be done because the prior was the case. The false estimate in both operations, where resection was done first and amputation subsequent, appears to be the *same*. Resection was done after the patient failed to improve from his wound, and amputation was done because he failed to improve from the resection. Hence we say we think of no case in which amputation ought to be done *after* resection has turned out badly. If resection, it should be done while the wound is freshest. If amputation, the operation may be delayed, but *without* any *interposition* of resection. Undoubtedly many cases, which only amputation could benefit, would be done at the proper time if the idea of resection did not interpose and *revert* that of amputation to be done as a later and following operation. We are not assuming that either operation would be better than *none*, for that is precisely the thing which should be decided, and either of the three decided *of itself* at the earliest moment, only that if it be resection, it should be done when the wound is freshest, and elsewhere herein we state what should be a substitute for complete resection, viz. the extraction of all the actually comminuted parts by a sufficient amount of cutting to freely accomplish this. We have before said the operation of resection should be decided on when the wound is freshest. Such indeed would be the rule in *amputations* in military surgery, were it not for the special reason of the existence of shock, and, for the time being, an impairment of the higher powers of the nervous system. But this special reason has but little weight in the less formidable operation of resection, since that requires but little ability in that system to sustain it, while the more formidable operation, amputation, exacts its full powers to survive it.

Seeing that the foregoing so forcibly presents itself, have we not reason as well as facts to urge us to the practice of resection at the earliest moment practicable, when the facts are, so far as I have gathered and presented them, to perform it at a late moment? Our present practice fails to *conserve* life and limb near so frequently, as in resections in civil life. The difficulties of the operation are not so great but that any surgeon competent to an amputation can creditably and successfully encounter them, and, however this may be, it is his business to do his best towards it, and not to leave it undone until he finds by a want of skill he fails. But, moreover, there are several very strong special *reasons* which urge us to the adoption of a frequent performance of resection nearest the time of receiving the wound, reasons which, although they are not in the repertory of considerations of the older living surgeons, respecting the operation in question, are of paramount character with the proficient in modern learning of morbid physiology. These are the facts concerned in every question of injury to the bones. By means of these facts alone, understood and credited, are we enabled to account for the very remarkable, and, as yet, in surgery, wholly un-

comprehended difference in the depreciation of vitality and reduction of the system, between wounds of the flesh, however large, and wounds of the flesh with breaking up of the continuity of the bone. These facts in the character of reasons, not less than others, impel us to adopt the earliest moment for our operation, before this depreciation and reduction of the system supervenes. Having learned the character of the processes in the formation of bone, and its minute anatomy, a knowledge which dates exclusively from the researches of Virchow, but little is needed to effect an understanding of how the breaking up of bone is so greatly injurious to the body. In a general sense we know that the extent of the injury is proportionate to the calibre of the bone, and not to the extent of the flesh injured, even in case the wound is compound. Hence it is familiar to us to regard a mere flesh wound lightly. That we do not habitually do the same when the injury to the flesh is a part of a compound fracture is solely because experience has taught us that when the *bone* is injured a wound is serious. Virchow taught us that bone is not in any sense a deposit, a regular accumulation of solid particles, but is constructed from materials flowing in the blood, in virtue of certain excessively minute channels and corpuscles—the bone corpuscle—of cellular character. These channels, at the first not unlike vascular capillaries, wall themselves in and become a firmly adherent lining thereto. They are then like an extended pore. Interposed everywhere are the "bone corpuscles," whose arrangements finish, so to speak, the complete skeleton mesh upon which the bony substance is organized; besides this there are the ordinary blood-channels which supply the material for the whole construction, while they themselves compose a part of it. Intimately investing these is the periosteum. It is perhaps getting the cart before the horse to say this *secretes* the bone, which it really does no more than the neurilemma secretes the "white substance of Schwann," or the "axis cylinder." It really maintains the whole intact, as an impermeable investment, and furnishes the anatomical bounds of the tissues on the one part, and the bone process, on the other, within which alone bone can be produced. Break this investment and the bone, and the little vascular channels do not occlude their openings in virtue of their own constitution, as bloodvessels do. Everybody who has observed the course of an amputation knows that they continue to ooze blood much longer than the cut soft tissues. For a first period they continue to do this, but next the red globules, as in ecchymosis, impact and disintegrate. Their di-integrated substance clogs up the porous channels, from which now gain issue only the phosphates and other saline materials of bone formation. These are added to the suppuration of the soft part. They are the richest and most life-sustaining materials of the blood, and it is the loss of these which, in part, constitutes the remarkably depreciating drain on the system in destruction of bone. The increased amount of suppurated matter invariably noticed in such cases is due in part to their addition to the products of suppuration in the soft tissues. But along with that, there is the latter exacerbated and aggravated, not only by what is ordinarily known as irritation by fragments, but also by the presence in them of the freed phosphates. The pieces of bone begin to disintegrate into smaller pieces, under conditions that do not admit of "absorption," and add their sum to the dead matter of the wound. Where the bone has hitherto been without an atom of room beside it, there is a space filled with tattered flesh, shreds of foul and sloughed tissue, crumbled and decaying fragments of bone, and liquid products of animal decomposition; while above all, all of this having ceased any organic connexion with the limb, from the moment it so ceased, has been the object not of physiological but *chemical* processes, developing foul and fœtid gases and diffusible poisonous and infectious organic particles. From the moment chemical change takes place in these, any reparative process, for the time being, is totally precluded.

The tissues yet in organic bonds, little by little yield and give way before the destructive contact of the putrescence. The vascular channel contains their moving supply of building matter, and the blastema for all formations in granulation, up to the point where the capillaries are terminated by occlusion, but they find no channel of return to the veins, and continue to infiltrate these substances into the tissues around. The infiltrated matter spreads above, below, and around as it is furnished, the arm everywhere becomes œdematous, and now the tissues of every description participate in the ruin. Absorbents, nerves, muscular tissue, and even the adipose tissue, change accordingly. This is the condition and course of morbid changes which more or less completely take place prior to the period, in the present practice of resection, when amputation or resection is performed. The surgeon may decide between the two at an *earlier stage* of this progress, but of course *later* he will have no difficulty in *deciding* on amputation, and in the performance of it is accomplished precisely what we have already said. Have we not facts, then, which produce our conviction that it would be better to operate *before* all this occurs? Such is the case in civilian resection, to which, perhaps, may be attributed its remarkable conservative successes.

The period of doubt in the cases in question is precisely the one when we should *decide* and perform. To act cautiously in doing a thing is *not* to leave it *un*done. The phrase "It is difficult to decide," occurring in medical literature, is accepted as meaning—*not* to decide. But what would the world think of the cultivators of other branches of science, who desist from their operations because there was a difficulty?

But the difficulty *whether* resection should be undertaken at the earliest moment of the wound, can only be removed by a change in the present practice of performing the operation when nature has left no room *for a choice.*

If he perform resection, the freshly cut surface, if at the seat of the wound, is exposed to the instant chances of contamination and infection, from the suppurating and sloughing tissue first wounded. If the line of his incision extend into a firm and undivided opening with any part of the track of the wound, the fresh surface will hastily assume all the foul character of the old wound. While, if his incision for the removal of the bone be apart from the original wound, there is the complication of two seats of suppuration, augmenting the draught upon the resources of the hapless patient.

We have seen in the cases we have numbered, that resections in military surgery, after the suppurative process is fully established, most frequently do not save from fatality, while we learn that in civil practice they most frequently *do* save from fatality. Undoubtedly, the former will never turn out as many successes as the latter; but perhaps, may turn out *more* than heretofore.

In the number of cases examined, there was discernible by me no fault in the treatment following the operation. I could imagine no improvements or change for the better in it. The dressings of four of my own cases were kept saturated by dilute tr. arnica. In three of these autopsy disclosed a foul and sloughy state of the wound—and the fourth was not observed by me.

Continuing our view of the present practice of resection, which leaves undone the operation until a late moment, we observe that by this failure the surgeon *forces himself* to adopt either resection, or amputation instead; when in either event, the state of the limb and the powerless condition of its owner, render him wholly unfit to recover from either. Operating has been left undone, until *either are alike a necessity.* Either one or the other cannot be said to *be a choice,* for the operation has been left, until both are equally futile or immediately dangerous. And as before it was postponed because postponement *could* be adopted, he now operates because it cannot *longer be postponed.* The conditions of choice no longer exist, because either of the operations which could before be chosen between,

must now be performed, if anything whatever is to be done.

But when this period has arrived the surgeon will most probably amputate—indeed, he will generally be driven to it as a *last resource*. Consider now, how an amputation under these circumstances stands. The wounded is in a state ineffectual to repair his losses or reunite his wound. To all his previous losses is now by amputation added that of so much blood. Between this, and allowing him to linger on—to continue without surgical interference, there is now *no choice*—nor between these two *and* resection, now, is there any more choice, that conservative surgery dictates. The three are identical in being ineffectual, except only in this particular, that amputation will effect the greatest *immediate* loss.

But, moreover, the demand for some rule is forcibly indicated in the fact, that most surgeons of a short experience—such is my own—will not operate without the guidance of rule already established. This is shown in the fact, that even now, in late resections, by a common misunderstanding they suppose they follow a rule—which is the rule of *not* operating until the progress of the wound has shown no attempt at improvement. But the truth is, to *uniformly not do* an operation, is not *to act upon a rule.*

The necessity of a rule, therefore, is plain; and our purpose is accomplished in having explained, that there are grounds for intimating that a rule can be reached by substituting for our present practice of late resections, in a proportion of cases, the practice of resection when the wound is fresh.

By the rule we ask and hope, for we mean, no more than one similar to the variable and imperfect, though advantageous and necessary ones taught and adopted in *amputations* in military surgery.

If we set any value upon the latter we should also do the same upon the former. The ablest surgeons in the country have thought the latter so valuable as to make a special and expensive effort to diffuse the learning pertaining thereto, through the Medical Staff of the army, in various documents; and the effort which has the purpose of finding and establishing the former is no less respectable, and even noble, however the event may prove as to its success. For the task of the surgeon, though not always successful, is creditable and even noble. The most perfectly complete and hideous, though refined selfishness, is that in which the surgeon will do no operation unless all the chances carefully calculated are in his favor; that is to say, in which all these chances prognosticate one operation more which shall successfully redound to his fame.

Reports of Societies.

NEW YORK ACADEMY OF MEDICINE.

STATED MEETING, June 18, 1862.

DR. JAMES ANDERSON, PRESIDENT, IN THE CHAIR.

DISCUSSION OF DR. BYRNE'S PAPER ON PELVIC HÆMATOCELE.

(*Continued from page 275.*)

[Conclusion of DR. BARKER'S Remarks.]

I DO not wish to detain the Academy but a few moments longer, and I will consequently only allude briefly to one or two other points.

With reference to its treatment. It is yet a disputed point among some of the best authorities, whether, aside from such treatment as common sense would suggest, such as relieving pain, etc., it is best to resort to surgical interference or await the absorption of the effused fluid. In a certain class of cases it is found that the contents of the cyst have disappeared, while in another class of cases the contents of the tumor become disorganized, inflammatory action takes place in the tissues surrounding, pus forms, and we have a discharge. If this discharge takes place in the peritoneal cavity, death of course is the result. It may take place into the uterus, vagina, bladder, or rectum, and then the patient is apt to get well. In other cases surgical interference has been resorted to, and this interference consists in evacuating the contents of the tumor. It is unsettled whether it is better ever to resort to this method, or whether to leave it to nature, with the hope of its being eventually absorbed; especially as in quite a large number of cases where surgery interfered, a certain proportion of deaths resulted. I can only give my own views upon the subject. When the tumor is not large, and where the amount of extravasation is not very extensive, and especially where it is extra-peritoneal, I should trust for a time to keeping the patient absolutely in the recumbent posture, and sufficiently under the influence of opiates to allay the peritoneal irritation, and to such means of invigorating the general system as may be indicated. But where the amount of extravasation is large, containing from six to eight ounces to three or four pounds, I believe it is truly impossible to expect to get absorption. We must expect, eventually, to have suppuration excited, and we may have very unpleasant results from it, or death, or we must resort to a surgical operation, and this consists in the discharge of the contents of the tumor.

One word or two, in regard to the surgical procedure. It has been recommended by some to puncture the tumor with a trocar and allow the discharge to escape through the canula. The author of this paper recommends that it be punctured, and he did it successfully in his case. He prefers the rectum, inasmuch as the discharge which takes place is less apt to be offensive than through the vagina. In carefully studying the reported cases I believe that this method is not the best one. No one should attempt to introduce a trocar until after all the acute symptoms are passed by. Then you have coagulation, ordinarily, of the contents of the tumor, which afterwards become disorganized, and it is very difficult to effect a discharge through the canula. I should theoretically object to the method of Dr. Byrne, and for this reason that the anterior and posterior walls of the rectum are always in contact, and thus the evacuation will be very imperfect, while the cavity of the vagina is much more elastic, larger, and much more complete, and evacuation through this canal will be more perfect. Instead of evacuating with the trocar I have used the tenotomy knife. I make a free incision through the posterior vaginal walls and bring out the matter with the finger.

The results of this case, which we have just reported, I will at some future meeting present. As to the case itself I am not prepared to say whether it should be subjected to surgical interference or trust to nature, but I am inclined to think that it is not safe to leave it for the suppurative process.

DR. FINNELL was surprised to hear that extravasation of blood from the ovary was of such rare occurrence, as he had frequently met with quite a large number of instances where this was the case. He had seen an extravasation equal in size to a hen's egg. In fact, so commonly was this condition met with by him in his post-mortem examinations of females who, while menstruating, had committed suicide, that he was inclined to think that it was almost a natural process, unattended with any particular symptoms.

DR. WHITE, of Buffalo, having been invited to make a few remarks, stated that the subject was almost entirely new to him. He had no doubt that previous to the time that he knew of the existence of such a disease as hæmatocele, he had mistaken for it other tumors—in fact, he could bring to mind two or three instances of the sort which came under his observation about twelve years ago. Since he had learned of the disease he had met with four cases, the histories of which were not very unlike those narrated by Dr. Barker. The first case he saw in consultation in Gainesville, forty miles from Buffalo. The patient had ceased to menstruate, and the symptoms came on very suddenly. A sound was introduced, and the uterus was

found in the normal situation. A large tumor was felt between the rectum and the sound, and so much pain was occasioned by its presence that some interference was demanded. Accordingly, an exploring trocar was introduced, and about an ounce of grumous blood escaped. A small tenotomy knife was then introduced, and then a director, and the whole was laid freely open. The patient made a slow recovery. In the next case the symptoms were not so urgent, neither was the tumor so large, and not knowing what to do nothing was done save the following of general indication. The patient was laid upon her back and the tone of the system maintained until she eventually recovered. She has since given birth to a child. In the third case the same course was advised as was taken in the last case, but suppuration took place, a large amount of pus was evacuated, and the patient only partially recovered. The fourth case he saw in consultation with Dr. Hanley, now of Greenpoint, some six or seven years since, an Irish woman completed her labor with a little more than the ordinary amount of suffering. She was then attacked with bearing-down pains. Dr. H. made an examination, thinking there was possibly another child, when he found a large tumor pushing forwards the posterior wall of the vagina. The pain continued very severe, and Dr. White was sent for. Dr. W. was at first quite at a loss to make out what it was, and at first thought it was an ovarian or other extra-uterine tumor that had been displaced. In the course of the examination his finger broke though the vagina, and a considerable quantity of blood escaped. The diagnosis was then made without difficulty. The patient recovered. In making deductions in regard to the effects of treatment in these four cases he was inclined to favor evacuation. In conclusion he stated that he entirely concurred with the general views of the disease as expressed by Dr. Barker.

Dr. Noeggerath remarked, that the prominent position which French literature had attained with regard to the subject of pelvic hæmatocele, almost to the exclusion of that of other nations, should not be a matter of surprise. All the several departments of uterine pathology have received their first impulse from France, while England and Germany have followed suit. Thus the doctrines of the engorgement, of ulcerations, of dislocations, of peri-uterine affections, owe their birthright to French writers. In order to add a few names which ought not to be forgotten whenever the subject of hæmatocele is under consideration, I call attention to the eminent labors of Drs. Devalz, A. Puech, Gallard, Viguès, and Laugier. A more scrutinous inquiry into the merits of these several authors I will reserve for a future time, which I intend to devote to the reading of a paper touching this interesting affection. Peri-uterine hæmatocele has come to my personal observation three times. In two of these cases I was called in consultation after the first and most striking symptoms had passed over, and a retro-uterine tumor, and slight traces of peritoneal inflammation, were the indications for treatment. Both recovered without surgical interference. The third case, which was one of catamenial hæmatocele, occurred in a young lady, seventeen years old, who had been suffering from intense obstructive dysmenorrhœa, for at least two years previous to the attack which I am speaking of. These sharp hypogastric pains went on, increasing in intensity with every succeeding menstruation. On this occasion, as soon as the menses began to flow, the patient was forced to keep her bed, and the pain very soon became so violent that she had to cry out aloud. Tenderness on slight pressure of the abdomen soon became very marked, and the pulse rose up to 120 strokes in a minute. The tincture of opium in frequent and large doses, as well as warm fomentations to the stomach, proved unavailing; pain and fever increased steadily; the abdomen began to swell, and by percussion the formation of a tumor occupying the pubic region and right iliac fossa could be demonstrated; all these symptoms developed themselves during the night; and on the following morning, vomiting, great prostration, facies hippocratica, paleness of the skin, with cool extremities, added proof to our diagnosis of effusion of blood into the abdominal cavity. The greatest distress was experienced by the patient from the constant and vain efforts to void the bladder and rectum. The treatment consisted of iced brandy and opium. The latter remedy, however, was rejected by the stomach, and not absorbed by the rectum, into which it was introduced in five grain doses. When, however, I at last resorted to hypodermic application, all the beneficial effects of the drug were developed in less than five minutes; the pain ceased at once, the pulse increased in volume and slackened in frequency. At about the sixth day, very copious, serous (not, however, bloody) discharges took place from the bowels, and they were constantly followed by a feeling of relief, and buoyancy of spirits. Occasionally, this watery diarrhœa became so frequent that we had to check it, for the time at least, being fearful it might bring on exhaustion of the already greatly reduced forces of the patient. It could be easily controlled by subcutaneous injections, about thirty of which were made on both forearms, and to them, I doubt not, the young lady owes her life, and the perfect health which she enjoys at the present moment.

If there is an affection of the female sexual organs which is accompanied with all the symptoms generally thought characteristic of peri-uterine hæmatocele, it is acute salpyngitis, *i.e.* catarrh of the lining membrane of the Fallopian tubes; and I am astonished that not one of the many authors on pelvic hæmatocele has made the slightest remark of this fact. It would be out of the way on this occasion to describe the entire pathology of this interesting disease, and I will only say, that in the location, acuteness, and suddenness of the pain, in the inflammatory action which it kindles in the pelvic cavity, in the severe reaction of the system, and even in the physical alterations appreciable by examination which it develops in the intra-pelvic organs, there is so much resemblance with the symptomatology of pelvic hæmatocele, that in some instances nothing short of a post-mortem examination will be able to decide in the one or the other direction. This was illustrated to me in the case of a young lady, who died from the consequences of acute tubal catarrh. The patient to whom I refer was an unmarried female of about eighteen years of age, who had crossed the Atlantic about eight months previous to this occurrence. She had always been healthy up to the time of her journey to this country, since which time she complained occasionally of scanty and painful menstruation, which, however, had never troubled her sufficiently to call for medical attendance. In the month of May, 1860, she was taken with a sudden fright from seeing a parcel of clothes set on fire, which had been placed near a stove to be dried. In the same moment, when the shock had moved her, she experienced a sudden pain in the abdomen; she fell to the floor, and was seized with convulsions. These were followed by a comatose condition, from which, however, she recovered in about an hour. After that the principal features of her case were a general nervous prostration, and an intense pain in the umbilical region. Without exhibiting any other symptoms, she sank rapidly, and died in about twenty hours after the accident above described had taken place. The post-mortem examination showed a normal condition of all the inner organs, with the exception of slight cerebral and meningeal congestion. The only traces of disease were found in the uterus, its appendages, and the pelvic peritoneum. The latter was in the first stage of inflammation, and its cavity contained about two ounces of an opaque serum. The cavity of the uterus was filled with a yellowish milky fluid, and its lumen almost obliterated by the enormously hypertrophied and inflamed mucous membrane. Both the Fallopian tubes were distended, and filled with a liquid resembling fresh, healthy pus. The ostium abdominale showed a quantity of this matter at its orifice, and on microscopical examination the liquid exuded in the pelvic cavity was found to contain quite a large number of round pus cells, and a considerable quantity of those peculiar columnar epithelial cells,

which only exist in the mucous membrane of the Fallopian tubes.

The causes of pelvic hæmatocele may be comprised under the following heads:—1. Hæmorrhage of the womb, the blood passing through the Fallopian tubes. 2. Hæmorrhage of the tubes. 3. Hæmorrhage from the ruptured follicle of a diseased—apoplectic or inflamed—ovary. 4. Hæmorrhage from the rupture of a varicose vein of the utero-ovarian plexus. 5. Hæmorrhage from a ruptured ovum developed outside of the uterine cavity. With regard to treatment, it may be said that surgical interference ought to be deferred until all other resources of our art have been tried; the tumor ought to be punctured with the trocar in all those cases, and only in those cases, where its persistence threatens the life of the patient. In twenty-nine cases where the operation was performed, twenty-two recovered, while seven died. I prefer the use of the trocar to that of the knife, because it has happened that patients died from hæmorrhage of a branch of the uterine artery which supplies the superior and posterior wall of the vagina and its peritoneal lining.

On motion, further discussion on the subject was deferred to the next meeting of the Academy.

FOREIGN CORRESPONDENCE.

LETTER XVI.

By PROF. CHARLES A. LEE.

COLONY OF FITZ-JAMES.

(*Continued from page 251.*)

On every Sunday the colonists are taken out to wash in groups of twenty or thirty; some are even allowed to go out freely without their companions, and have never yet given the proprietors cause to regret the allowance of such liberty.

The organization of labor, then, is the essential feature in the treatment of the insane at the colony of Fitz-James. The regularity of life, the disciplinary order which characterizes every description of work, the kind of occupation assigned to every individual, according to his aptitude, all these are of the greatest importance, in exercising or diverting the feeble or perverted faculties. Each colonist finds, in the diversity of occupation which daily presents itself, all the elements favorable to the development and the exercise of his physical and intellectual activity. The inmates find here, apart from the occupations in which they are generally employed, the conditions of freedom and domestic life, which are very difficult to meet with in a large collection of patients. To this end is the peculiar arrangement of the sections, which are organized to receive but a small number. Many have their own servants who accompany them in their walks; some have the privilege of going out alone; and without quitting the colony, they find in the incessant movements incident to such extensive agricultural employment, sufficient to divert their minds, and render their sojourn agreeable. The colony thus offers to convalescents and tranquil curable patients, the most prompt means of hastening their recovery; it gives a salutary activity to their physical powers, by the wise application and selection of employment, and it moreover induces a favorable modification in the character of their mental disorder, and by the great freedom here enjoyed, they gradually become accustomed to the habits of domestic life. Even the incurable acquire in the discipline and regularity of life, here enjoyed, habits of order and of work, which makes them docile and industrious laborers.

At *Becrel* where the laundry is carried on, and employment requiring a certain amount of attention and constant physical exertion, the females are, for the most part, selected from the excited patients at the asylum. The washerwomen are nearly all afflicted with noisy delirium, and cannot be made to submit to the calm quiet of the workshop; they are generally selected from the more robust, and those best capable of performing this kind of labor. Those who spread out the clothes are selected from the melancholy patients; while the imbecile idiotic are entrusted with the duty of carrying the clothes from the wash-room to the drying department. The duty of selecting and folding the clothes is allotted to the tranquil monomaniacs, whose fixed ideas, hallucinations, allow sufficiently sustained attention Many of the convalescents, and some pay patients, are employed in this last occupation and in sewing.

The number of patients employed in this section is as follows: Washerwomen, fifty-four; folders, eight; dryers, eight; carriers, six; general duties, six; sewing, twenty-five; total, one hundred and seven. The *farm-labor* is so diversified as to furnish suitable employment to all kinds of mental derangement; every patient can be made useful in some way, as there is a great choice of useful and attractive occupation. The colonists are all organized into detachments, and each detachment points out, as it were, the intellectual aptitude of the individuals composing it. Such special workmen as are essential to agriculture, as cartwrights, blacksmiths, joiners, painters, etc., are also selected from the patients, and employed under the direction of the chief mechanic. The laborers of the field and the workshop, the care and management of the animals, the agricultural implements, etc., are distributed among the mechanics, monomaniacs, and demented; while the imbecile idiots are charged with the management and cleanliness of the court-yards, the cow-stables, the carriages, carts, etc. The patients engaged on the farm may be summed up as follows, according to the nature of their occupations:—Farmers, sixty; vegetable gardeners, fifteen; cowherds, eight; hostlers, six; swineherds, eight; shepherds, four; drivers who have charge of agricultural implements, five; laborers, ten; house service, twenty; cooks, three; engineers, two; farriers, one; turners, one; cartwright, one; painters, one; butchers, two; children, more or less occupied according to their fitness, twenty-two; total, one hundred and seventy. The director of the colony marks out every morning the labors for the day; these orders are given to the chiefs of the workshops, or detachments, consisting of twelve or fifteen in number, who see that they are faithfully carried out.

The division of time varies according to the season of the year. In summer the colonists rise at five o'clock in the morning, make their beds, take their first meal, and go to their work at six o'clock. They return at eight for breakfast, resume their labor at nine, and return at eleven. They spend three hours at rest and partaking a second meal (*dejeuner*), and return to labor at two, continuing it till four. They then repose and take a lunch till five, and the labor of the day closes at half past six, when they have supper, and retire to sleep at eight.

In winter they rise at six, take their first meal, but do no work till seven or eight; nothing is done on the farm at this season. After the first meal they work till nine and then rest till noon; at mid-day two hours are devoted to eating and repose; from two to four or five they work; then supper at six, and to bed at half past seven. They thus work but six hours per day. Some reward is allotted to each workman, according the importance of his work, and some addition to his ordinary food.

I noticed at the farm, a collection of idiotic, or imbecile children, most of them, as usual, marked by imperfect cerebral organization; some of them apparently without any brains at all. Among them was one well marked cretin, without goitre, from Savoy. They occupy by day a schoolroom, and have a dormitory entirely separated from the other patients. They spend four hours every day in school. During the interval of their school hours, some are occupied on the farm, the others are walking over the grounds. When they reach a certain age, and are susceptible of the least education, they enter the workshops of the asylum at Clermont, and are assigned some occupation. Some of them are already tailors, shoemakers, joiners, locksmiths, etc., and very useful workmen.

I have already stated that the results of this colonizing experiment have been remarkably successful. Imbeciles, idiots, the demented, the violently excited, and dangerous

patients, all have become docile workmen, and as industrious as the sane and intelligent. Even the miserable incurables, who have always been more or less dangerous, and a charge to their family, have, after a period of this disciplinary labor, been returned to their homes quiet and orderly, and capable of lucrative employments. The convalescents and curable remain generally but a short period, their mental condition rapidly improves; the others are restored to their poor families as soon as they can be made useful. At the same time the proprietor derives considerable pecuniary profits from their labor. The establishment, in fact, is a practical school of agriculture. All new modes of cultivation, all new and useful agricultural implements, are being constantly introduced and tested, and as the colony is situated in one of the most productive agricultural provinces of the kingdom, these experiments are of the greatest benefit to the farmers in the surrounding districts. Here may be seen the new mowing and reaping machines, ploughs, harrows, etc.; the raising and fattening of improved breeds of cattle, sheep, and swine; here are the finest draught horses in France; the best dairy cows, etc., and all this is evidenced by the numerous first prizes, which have been awarded at different agricultural fairs. All the buildings, courts, stables, etc., are kept in the very cleanest and best condition; every tool and instrument, after being used, is cleaned, and put in its appropriate place; the animals are all fed at fixed times; in short, all the details of the wisest and most careful administration, impart to those who are employed in carrying these out, and who can appreciate their advantages, a sense and habits of order and care, which they carry away with them, and which are ever after of the utmost benefit.

The population of those departments which send their insane to this establishment, is essentially an agricultural one; and they accordingly highly appreciate the great advantages of such an establishment; for they are constantly witnessing its beneficial effects on those who are returned in health to their homes, and who at once reduce to practice the knowledge they have acquired, and continue the industrious habits in which they have been so successfully trained.

Although great liberty is allowed to the patients, the attempts to escape do not average more than five or six in a year, and as they all wear a peculiar uniform, they are easily recognised and returned to the colony. No case of suicide has ever occurred in the establishment, although very large numbers of melancholics with suicidal propensities are sent to it. Thus, constant employment, and its interesting and diversified character, gives a favorable diversion to their thoughts, and then, the colonists themselves have a special surveillance over each other; and, if there are any who are predisposed to injure themselves, the more tranquil are advised to keep special watch over them. They are always working together in detachments; and if there is any attempt at escape or suicide, those who prevent it and give information are rewarded. In short, they form a mutual protection society, and there naturally spring up among them sentiments of intimacy and attachment, which exert a favorable influence over their moral faculties, and render their life in common agreeable and attractive. They soon learn to appreciate these friendly offices, and in a short time get rid of that suspicion which generally characterizes the insane.

During the last twelve years, in spite of many discouragements and obstacles, this Institution has been constantly increasing in prosperity. Beginning with 735 patients, it now has over 1300—1200 being the number to which it is limited by Government—561 males, and 666 females; of whom, 1012 are indigent, and 215 pay-boarders. Patients are sent to it from three departments, who pay one franc per day for males, and 95 cents for females. The pay-patients pay from $600 to $1000 per year, according to accommodation, number of attendants, etc. In short, the Institution is not only self-supporting, but a source of wealth to its proprietors.

The following statistics may serve to show the general results of the management. From 1851 to 1859, 3788 patients were admitted—1871 men, 1916 women; of these 2428 were incurable, 1360 curable. The incurable males forming 75·16 per cent.; the incurable females 58·24 per cent.; 24·84 males curable; 41·76 females do. Total, 67 per cent. incurable, and 33 per cent curable. There were discharged during the same period, 251 men and 233 women, total 584, cured; 141 men and 116 women, total 257, convalescent and much improved; total 841 cured, or convalescent; while 167 men and 114 women, total 281, remained uncured; 29 escaped, 17 men and two women; total discharged or escaped, 1152.

American Medical Times.

SATURDAY, NOVEMBER 22, 1862.

MANAGEMENT OF MILITARY HOSPITALS.

The last number of the Medical Times contains a paragraph relating to the military hospitals of the United States which will attract attention. From this statement it appears that there are now one hundred and fifty General Hospitals, containing in the aggregate sixty thousand five hundred and fifteen sick and wounded soldiers. The necessary attendants upon these hospitals, exclusive of medical officers, number nearly twelve thousand, as follows:—stewards, four hundred; ward masters, three hundred; male and female nurses, six thousand and fifty-one; laundresses, three thousand and twenty-five; cooks, two thousand and seventeen.

It would be surprising if a system of hospitals on a scale so grand and comprehensive should not attract popular attention. But when it is remembered that the patients are drawn from the families of the people at large, and that every neighborhood, and nearly every hamlet, has its representative in these institutions, the intense interest with which the public regard them is explained. No institutions in the entire country are so frequently visited, and the management of none is watched with equal solicitude. The most vague and indefinite rumor of mismanagement in any hospital arouses the popular sympathy; and the matter is at once and thoroughly investigated by voluntary committees of the people. If there is an abuse, the offender is sought out, and the popular voice imperatively demands his ejection and disgrace. If simple representation of the results of their inquiry to the proper authority does not promptly effect the object, they resort to the press and make inflammatory appeals to the public. Local associations in all parts of the country have their agents constantly visiting their wards, prepared both to provide for the wants in the hospital stores, and to detect and report abuses in management. The people may truly be said to have taken the military hospitals under their special guardianship. While it is true that many instances of what appear to be abuses to those unfamiliar with hospital management are but the necessities of circumstances beyond the control of the officers, or, perhaps, are really necessary to proper discipline, it cannot be denied that abuses do exist which need correction. They are, however, of a character to be appreciated fully only by a pro-

fessional reader. To some of these we shall briefly allude.

The first great error noticeable in the management of our military hospitals is deficient ventilation. Medical men and architects are not fully impressed with the importance of pure air in the prevention of those affections so prevalent and peculiar to hospitals. In the construction of these buildings they are solicitous principally about the warmth of the wards, and are almost regardless of the location and size of the windows, the position of the ventilating flues, and the arrangement of the beds. We have been astonished at the indifference of Surgeons-in-Charge to the therapeutic value of an abundance of pure air in the treatment of low forms of surgical disease, as gangrene, erysipelas, pyæmia, etc. Not unfrequently these cases, occurring in a ward, are isolated by being crowded closely into the corner, away from the window, from the currents of in-coming air, and from the sunlight. Here the poor victim, whose body is undergoing rapid textural dissolution under the disintegrating influence of a hospital blood-poison, inhales not only the emanations of his own decomposing tissues, but also of the fomites which fills every unventilated nook of a ward. It occasionally happens that we find among the regulations of a hospital that erysipelas, gangrene, pyæmia, and typhoid diseases are to be grouped together in a damp, unventilated, gloomy ward, in which it is not thought proper to place any other form of disease lest the patient should rapidly become typhoid. It were well if the recent teachings of an eminent surgeon, that *pure air is the best remedy for pyæmia and allied diseases*, were posted in large characters on the walls of every hospital-ward.

Failure to appreciate the value of thorough ventilation leads to the next most noticeable feature in hospital mismanagement, viz. *over-crowding*. In the French military hospitals 1700 cubic feet of air-space are allowed by regulation to each patient. In this country the minimum is fixed at 1000 cubic feet. And yet of our 150 military hospitals, we venture the assertion that not five per cent. allow 800 cubic feet of air-space to each patient, whatever may be their system of ventilation. In the majority 700 cubic feet is the maximum of air-space to each patient, and from this point hospitals may be instanced representing various figures in the descending scale as low as 250 cubic feet. And this last amount—little better than the famous Black Hole—is the maximum of air-space allowed in hospital buildings originally constructed for barracks, and almost destitute of ventilation. In large numbers of hospitals the beds are arranged at given intervals, without the slightest regard to the cubical area of the wards. The results of over-crowding are apparent in every hospital where it is practised, in the prevalence of low forms of fever, erysipelas, etc.

Allied to defective ventilation and over-crowding in its effects upon the diseases of the inmates, is lack of cleanliness of wards, and imperfect police of the grounds. In general the wards of our military hospitals present a good appearance on inspection; the beds are clean, and the floors show the effects of recent scrubbing. But a more minute examination reveals, *under* the beds, old clothes, soiled dressings, and a thousand nameless filthy articles which patients always endeavor to conceal about them. The bath-room and bath-tub are too often the temporary receptacle of every uncleansed or unemptied chamber vessel, of soiled and offensive linen, and of every slop that a lazy nurse does not care to remove. The laundry, the kitchen, and mess room frequently exhibit the same untidiness. If we extend our inspection to the grounds, we are still more impressed with the utter disregard of cleanliness which some medical men in charge of hospitals exhibit. Refuse material, and heaps of decomposing animal and vegetable matter, strew the grounds, and fill every undrained and unventilated corner. The privies are open vaults, alive with vermin, and constantly emitting volumes of foul, disgusting, and poisonous gases. These are diffused throughout the adjacent hospital buildings, adding tenfold to the fatality of typhoid diseases.

The last item of hospital mismanagement is the regulation of the diet. That great abuse has existed in providing suitable food, both in quality and quantity, is notorious. But to whatever extent this abuse may have been carried, we believe that the admirable "diet table" recently prepared by the SURGEON-GENERAL, and about to be enforced in all the hospitals, will effectually remedy this evil.

In reviewing these more noticeable defects in hospital management, we have alluded in general to exceptional cases. As a whole, our military hospitals are conducted with commendable intelligence and efficiency, when we reflect that but few surgeons in charge have had any previous training or experience in hospital management. The exceptional instances where these abuses exist, are under the vigilant supervision of the Medical Department, and the day is not distant, we trust, when they will cease to be.

THE WEEK.

SEVERAL Surgeons of Boston have addressed a letter to Surgeon-General HAMMOND, U. S. Army, representing that the sick and wounded require more careful attention and protection against neglect, and the performance of needless operations. They believe that a considerable proportion of the surgeons in the army are "incompetent as operators, and also incompetent to judge when operations are required, and at what time and under what conditions of the system they can be safely performed." They add: "We have reason to believe that the profession has been disgraced by many of its members, who, having no just conception of the sacred duties of their calling, have entered upon it from wholly selfish and mercenary motives." They suggest as a remedy that the Surgeon-General "appoint a sufficient number of surgeons, who shall be men of acknowledged ability and experience in surgical injuries and operative surgery, to each Corps d'Armée, Division, Brigade, and dépôt for the wounded, whose duty shall be a general supervision of the wounded, in examining personally, so far as can be done, all the wounded, whether on the field, during or after a battle, in a general or other hospital, or at any dépôt for the wounded, and to decide as to the primary surgical treatment in the cases presented; and, if any operation is deemed necessary, to direct a suitable person to perform it, and at the proper time; and, furthermore, that no important operation, such as amputation of the large limbs, ligature of any of the principal arteries, or excision of bone, should be performed, except under great sudden emergency, till one or more members of this supervisory board shall have given his or their approval."

In his reply the Surgeon-General acknowledges the in-

competence of many medical officers, and states that he has made every effort to secure qualified surgeons to superintend the operations on the battle-field, but without success. He adds: "I am free to confess that first class surgeons have not come forward for field service with the alacrity that is to be desired."

This is a subject of very grave importance, and one to which we have repeatedly called attention. The spasmodic and wholly unorganized efforts which are made by surgeons in civil practice *after* great battles, have resulted in little else than great discomfort and inconvenience to those who have visited the battle-field. What is required is the selection of a sufficient number of experienced and thoroughly competent surgeons in different parts of the country who shall be in readiness at the summons of the Surgeon-General to visit the battle-field *before* the engagement, and to remain while their services are required. Such surgeons should have pay sufficient to compensate them for their personal sacrifices, and, if possible, such rank as will make their position respectable. Is not this a proper subject for the Sanitary Commission? Our Boston brethren have been active in every good work during the war, and we hope they will be able, in concert with the Surgeon-General, to devise a plan by which the best surgical talent of the country can be made available on future battle-fields.

In this number we conclude Prof. Clark's papers on Albuminuria. They form one of the most important contributions yet made to this subject, and have widely attracted the attention of the profession.

Army Medical Intelligence.

THE SERVICE OF THE FLOATING HOSPITAL "EUTERPE."

[To the Editor of the American Medical Times.]

Sir:—The Euterpe is a 2,000 ton clipper ship with only two decks. This peculiarity of construction in a vessel of her size gives an unusual air-space between decks; there being ten feet in the clear from the main to the spar deck. She is, without doubt, one of the most seaworthy and the steadiest vessel in a high sea, whether at anchor or in motion, that has ever been built. Her spar deck is very well arranged with hospital kitchen, mess rooms, officers' and nurses' quarters, dispensary, and cold and hot water reservoirs, etc., etc. Her main deck, which is most admirably adapted for general hospital purposes, as might be inferred from the large space between decks, has been very completely fitted up with the appliances and conveniences required in a well arranged hospital. This will accommodate two hundred and fifty patients, and give them all the benefits and comforts of a hospital. There are one hundred and eighty-six stationary bunks in tiers three high, and an abundant floor area for sixty-four movable cots, which do not interfere with easy access to every bed. Consequently the hospital will accommodate, with proper distribution, two hundred and fifty cases of the most serious average character which ever demand hospital accommodation. Beneath the hospital deck is an ample space for the requisite hospital stores, furniture, and general supplies, which is conveniently arranged with storerooms and compartments. The "Euterpe" actually began service about the middle of July, at Fort Monroe, when two hundred and twenty-two severe cases of sick and wounded soldiers were admitted into the hospital to be transported to New York. These were brought to this place during a heavy north-east storm in tow of the steamship Vanderbilt, and the unanimous statement of the patients was that they had enjoyed the comforts and conveniences of a hospital without any unpleasant experience of the sea movement. This was also confirmed by Dr. Sloan, Medical Director, who stated that he had never seen before the same number of serious cases arrive at this port in such a satisfactory condition, or a hospital transport in so excellent a sanitary state. After discharging the patients, the "Euterpe" returned to Fort Monroe on the 1st of August. On the 6th of August one hundred and forty-four grave cases from Richmond, which were mostly surgical, were admitted into the hospital. These patients were in a very prostrated condition, and the wounds generally sloughing or inflamed to a high degree, resulting from the improper surgical treatment received and the rough transportation undergone. Three days after the receipt of these patients the "heated term" of August began, and continued about a fortnight. During this period, with more than a hundred profusely suppurating wounds, and hospital and other diseases, such as dysentery, peninsular fever, etc., there was not a single case of infection originating in the wards, although one case of erysipelas had been received and not isolated. The temperature also of the hospital was several degrees lower than in any shore hospital in the vicinity of Fort Monroe. There was likewise a thorough circulation of the atmosphere maintained by the numerous ventilators and wind sails, so arranged as to inject strong currents of air, and the abundant escapes through side-ports and hatches; so that in any respect the sanitary condition of the Hospital "Euterpe" compared most favorably with any hospital that has come under my observation. On the 27th of August ninety-eight patients were received who had been under treatment in the Portsmouth Hospital. The majority of these were severe surgical cases, and a large percentage of them were suppurating wounds, which were generally in a sloughing or inflamed state. Two cases of "erysipelas," also, were included in this number, and one case of hospital gangrene. During the after treatment of these two hundred and forty-two cases the sanitary constitution of the hospital was maintained in the most satisfactory manner, and the progress of the surgical cases, also, was quite as favorable as in any well regulated hospital. There was not a case of erysipelas or hospital gangrene originating from those introduced, and every inflamed sloughing wound, except the case of hospital gangrene, rapidly improved and assumed a healing character. The results obtained from the treatment of the two hundred and forty-two cases alluded to were, on the 1st of October, as follows:—One hundred and thirty were returned to duty as convalescents cured; forty-one were discharged from service as permanently disabled; twenty-eight died, and forty-three convalescents remained in hospital. Among these cases are many interesting and novel surgical incidents, which hereafter I shall take occasion to communicate through the medium of your journal. During the month of September the "Euterpe," being at anchor in Hampton Roads, was exposed to the equinoctial and autumnal storms, but on no occasion were the patients disturbed by the motion of the vessel, which was always very slight comparatively. On the 10th of October patients began again to be admitted from the hospitals in the vicinity of Fort Monroe, and on the 18th the complement of two hundred and fifty having been received in hospital, I proceeded with the "Euterpe" to New York, and arrived on the 20th with the patients and hospital in excellent condition.

Thus terminated the service of the "Euterpe" as a Transport and Floating Hospital under my administration, and I can state that it has been an exceedingly gratifying experience. In conclusion I think the "Euterpe" has been fully tested as a Floating Hospital as well as a Transport, and has proved a perfect success. There is now no doubt in my mind that it is feasible to have Floating Hospitals, which will be as convenient and produce as favorable re-

sults as any land hospitals. And in my opinion there is a service of vital importance for which Floating Hospitals are especially adapted, and might recompense for the large outlay. I refer to those occasions where military operations are being conducted in proximity to the sea, bays, or large water courses, and are liable to sudden change of locality. There, general hospitals, which can be moved without disturbance of the patient, would be of the greatest consideration and benefit. I cannot close without stating that much of the success of the "Euterpe's" service was owing to the efficient cooperation of my associates as Assistant Surgeons, who were the following gentlemen:—Geo. F. Shrady, J. B. Ponce de Leon, B. L. B. Baylies, New York; Calvin Ellis, John Stearns, Haskett Derby, Boston; J. T. Day, 10th Maine; Evelyn Bissell, 5th Conn.

Yours, etc.,

J. King Merritt,
Late Surgeon in Charge.

BATTLE OF CORINTH—REPORT OF MEDICAL DIRECTOR CAMPBELL.

Head-Quarters Army of the Miss.
Corinth, Miss. Oct. 24, 1862.

General:—In anticipation of an engagement with the enemy on the 24 of October, upon information derived from the Engineer Department, I selected the large building recently constructed for a Commissary Depôt, as the place best protected by the nature of the ground and the safest for hospital purposes.

The men furnished by the Quartermaster worked expeditiously, and everything was prepared. Medicines, instruments, cots, and buckets of water were ready for some time before the first wounded man was brought in.

It became evident in a short time that the building, though a very large one, would be altogether too small. According to your order issued upon my recommendation, I then took possession of the Tishimingo Hotel, and when it was full, of the Corinth House, as hospitals, preparation having been made in the morning for that purpose.

All the surgeons worked diligently, and by six o'clock the wounded were all comfortably disposed of, and their wounds dressed.

At three o'clock next morning I received your order to remove all the wounded to Camp Corral. By six A. M. they were all collected into the new hospital. The ambulances then went to the scene of action to bring off those recently fallen.

I am particularly indebted to Surgeon J. L. Crane, Medical Director of Stanley's Division, who superintended the arrangement and pitching of the tents, and to Surgeon H. Wardner, Medical Director of Davies' Division, who received and disposed of the wounded as they arrived on both days.

I found on the R. R. platform a large number of tents, which I took possession of, and used. The battle ceased just before noon, and by night all the wounded were under shelter, their wounds dressed, and provided with cots.

I have to compliment all the surgeons for their kindness, energy, and indefatigable endurance. Surgeon E. Winchester, 52d Ill. Vols., in charge of the Corinth House, Surgeon S. P. Carpenter, 5th Iowa, in charge of the Tishimingo Hotel, and Dr. Swaring, at the Commissary Building, remained until the last man and all the property had been loaded and removed to the newly-selected hospital.

The wounded, being thoroughly arranged and cared for, were turned over on Sunday morning, 4th inst., to Surgeon Norman Gay, in charge of the General Hospital, an ample supply of Medical Officers was left to take charge of them, and the Surgeons of Divisions and Regiments, with one Assistant to each regiment, reported back to their commands, and joined in the pursuit of the enemy, which occupied from eight to ten days.

I have to state that there was neglect on the part of the rebel surgeons for their wounded. The surgeon placed by Van Dorn in charge of over one hundred wounded at Ripley, neglected to make out a requisition, with the assurance that all he needed would be delivered to him within forty-eight hours. Everything that has been called for from their large hospital at Iuka, and the other hospitals within our lines, has been furnished them on your order, except blankets, of which our supply ran short. They received the last on hand; the balance will be sent as soon as possible.

It is due Private H. B. Douglas, Co. A, 36th Ill. Volunteers, who acted as my orderly, both in this battle and that at Iuka, to say that no man was exposed to more danger, or could exhibit more bravery than he did, in the performance of his duty.

Herewith annexed is a list of the names of the killed, wounded, missing, and prisoners:—

	Officers.	N. C. O.	Privates.	Total.
Killed, ...	32	60	223	315
Wounded, . . .	86	276	1450	1812
Missing, ...	3	12	200	215
Prisoners, . . .			17	17
Total, . . .	121	348	1890	2359

The loss of the enemy, calculated from the best sources of information within my reach, was 1423 buried; 3000 prisoners, including their wounded, left in our hands; 5000 wounded taken away, and dropped by the wayside, making 9423.

Very respectfully your obedient serv't,

A. B. Campbell,
Med. Director, Army Mississippi.

Medical News.

TRIBUTE TO THE MEMORY OF JOHN C. CHEESMAN, M.D.

At a quarterly meeting of the Trustees of the College of Physicians and Surgeons in the city of New York, held on Tuesday, Nov. 11, 1862, the following resolutions were unanimously adopted:—

Resolved, That the Board of Trustees of the College do hereby offer a tribute of respect to the memory of their Senior Fellow Trustee, John C. Cheesman, M.D., deceased on the 11th ultimo.

For nearly fifty years a distinguished practitioner of medicine in this city, and for thirty-five years a member of this Board, he has uniformly proved himself a steadfast friend of the College, and promoted its prosperity by his influence.

Resolved, That in common with an extensive circle of confiding friends, this Board regards the decease of one so eminently skilful and successful in the practice of his profession, as was Dr. Cheesman, as a great public loss.

Resolved, That the Board beg leave hereby to express to the family of the deceased their sincere sympathy with them in their bereavement.

Resolved, That the Registrar be requested to communicate a copy of these resolutions to the family of Dr. Cheesman.

West Philadelphia General Hospital.—A new Department has recently been organized in this model Military Hospital, for the treatment of diseases of the eye, and placed under the care of Dr. Ezra Dyer as its surgeon. This hospital appears to be a favorite institution of Surgeon-General Hammond, who draughted the plans, had a supervision of its construction, and personally selected its corps of surgeons.

The contractility of the large veins, and especially of the inferior and superior venæ cavæ at their openings into the heart, in some lower vertebrata, has long been known; but now M. Colin informs us that the venæ cavæ of mammalia, at their openings into the heart, possess rhythmic and pulsatile movements similar to those pointed out by M. Flourens as existing in the veins of batrachia.—*British Medical Journal.*

DEATH.

LYMAN.—On Friday, Nov. 14, in discharge of his duties at Harwood Hospital, Washington, D. C., DR. FRANCIS R. LYMAN, Acting Assist.-Surgeon U.S.A., late of Sherburn, Chenango Co., N. Y., in the twenty-fifth year of his age. Dr. Lyman was a graduate of the University Med. College, N. Y. He entered Bellevue Hospital soon after his graduation, where he remained until he completed the full term of service on Oct. 1st. At this time he passed an examination for the place of Acting Assist.-Surgeon of Volunteers, and was assigned to duty at Harwood Hospital, Washington, where he took the fever, of which he died. Dr. Lyman was a young man of much promise in his profession. He was a diligent student, a conscientious physician, and a steadfast friend.

METEOROLOGY AND NECROLOGY OF THE WEEK IN THE CITY AND COUNTY OF NEW YORK.

Abstract of the Official Report.

From the 10th day of November to the 17th day of November, 1862.

Deaths.—Men, 86; women, 82; boys, 93; girls, 83; total, 344. Adults, 163; children, 176; males, 179; females, 165; colored, 8. Infants under two years of age, 112. Children born of native parents, 15; foreign, 137.

Among the causes of death we notice:—Apoplexy, 2; infantile convulsions, 11; croup, 28; diphtheria, 17; scarlet fever, 4; typhus and typhoid fevers, 13; consumption, 49; small-pox, 0; measles, 0; dropsy of head, 18; infantile marasmus, 17; cholera infantum, 2; inflammation of brain, 7; of bowels, 9; of lungs, 26; bronchitis, 7; congestion of brain, 2; of lungs, 12; erysipelas, 0; diarrhœa and dysentery, 9. 176 deaths occurred from acute diseases, and 36 from violent causes. 210 were native, and 134 foreign; of whom 85 came from Ireland; 19 died in the City Charities; of whom 4 were in Bellevue Hospital, and 3 died in the Immigrant Institution.

Abstract of the Atmospherical Record of the Eastern Dispensary, kept in the Market Building, No. 57 Essex street, New York.

Nov.	Barometer.		Temperature.			Difference of dry and wet bulb. Thrm.		Wind.	Mean amount of cloud.	Humidity Sat'tion, 1000
1862	Mean height.	Daily range.	Mean	Min.	Max.	Mean	Max.			
	In.	In.	°	°	°	°	°			
8th.	29.84	.21	33	25	40	4	5	NE to SW	10	730
9th.	29.71	.24	35	33	36	5	7	NE to SW	8	681
10th.	30.10	.41	44	37	50	7	11	W.	1	594
11th.	30.20	.20	44	38	50	5	9	S.	3	677
12th.	30.00	.26	45	43	51	3	6	S.	9.7	790
13th.	30.11	.14	50	45	54	7	12	N.W.	3	569
14th.	30.14	.15	47	40	55	7	11	W.	2.4	610
15th.	very high 30.34	.30	35	28	40	7	12	N.W.	.07	560

REMARKS.—8th, Sleet early A.M., cloudy all day. 9th, Return storm with snow; night clear. 10th, Clear, fresh wind all day. 11th, Fog; Indian summer night and day. 12th, Very light rain. 13th, Rain; P.M. clear, night clear. 14th, Clear; P.M. variable; night clear. 15th, Clear all day, with fresh wind. Melted snow and rain one inch and a quarter for the week.

To the Medical Profession.—Dr. I.

PARIGOT, Honorary Professor of the University of Brussels, late Commissioner in Lunacy, and Superintendent of Gheel, has opened an Institution at *Hastings, on the Hudson*, for the cure of mental and nervous diseases. The house is situated in a delightful and retired spot near the Hudson with vast grounds and gardens. The system employed in this new institution (that of *free air and family life*) is based upon the moral and physical liberty of the patients who voluntarily submit to medical treatment.

Dr. P. is permitted to give for his references several gentlemen of the highest scientific authority, and Superintendents of Asylums of the United States. In town he may be consulted at Dr. Elsberg's office, 153 West 15th street, on Tuesdays and Saturdays, for mental diseases and medico-legal questions.

New England Mutual Life Ins. Co.,

BOSTON AND NEW YORK, ORGANIZED 1843. **ASSETS, $2,350,000.** Documents showing the benefits of Life Insurance with the advantages of the Mutual plan, and the superior position and marked success of this Co., and explaining the different kinds of Policies with their methods of payment, may be obtained free of expense, upon application, either personally or by mail, to JOHN HOPPER, Agent and Attorney for the Co., Metropolitan Bank Building, 110 Broadway, New York. ☞ *Parties at a distance may insure from Blanks, which will be forwarded free of expense.*

On the Various Contrivances by

which British and Foreign Orchids are fertilized by Insects, and on the good effects of Intercrossing. By Charles Darwin, M.A., F.R.S., etc. 8vo. London, 1862. $3.60.

BAILLIERE BROTHERS, 440 Broadway, N. Y.

On Urine, Urinary Deposits, and

CALCULI: Their Microscopical and Chemical Examination, including the Chemical and Microscopical Apparatus required, and Tables for the Practical Examination of the Urine in Health and Disease; by Lionel S. Beale, M.D. Illustrated with numerous original Wood Engravings. Post 8vo. London, 1861. Price $3.40.

BAILLIERE BROTHERS, 440 Broadway, N. Y.

Dr. Churchill's Hypophosphites.

PREVENTION AND CURE OF CONSUMPTION

A supply of these important medicines,

SYRUP OF HYPOPHOSPHITE OF SODA,
SYRUP OF HYPOPHOSPHITE OF LIME,
PILLS OF HYPOPHOSPHITE OF QUININE,
PILLS OF HYPOPHOSPHITE OF MANGANESE,

has arrived from Paris with directions for use. Persons suffering from chest affections can now procure the above preparations genuine, as used by Dr. Churchill from the following agents in America.

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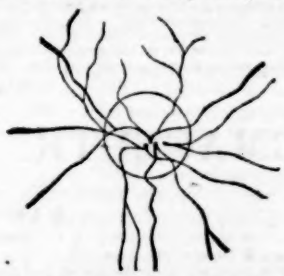

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